Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012107	A. BUILDING _____ B. WING _____	R-C 02/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODVIEW AL LLC	**3320 E STATE BLVD FORT WAYNE, IN 46805**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaints IN00122459 and IN00122565 completed on January 31, 2013. Survey date: February 25, 2013. Facility number: 012107 Provider number: 012107 AIM number: NA Survey team: Christine Fodrea, RN, TC Census bed type: Residential: 87 Total: 87 Census payor type: Other: 87 Total: 87 Sample: 5 Woodview AL LLC was found to be in compliance with 410 IAC 16.2 in regard to the PSR to the Investigation of Complaints IN00122459 and IN00122565. Quality review completed on February 25, 2013 by Randy Fry RN.	{R 000}		